		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020610

Facility Name: Wabash Christian Retirement

Address: 216 College Boulevard (Number) Carmi (City) 62821 (Zip Code)

County: White

Telephone Number: 618-382-4644 **Fax #** ( )

HFS ID Number: 37-0841562002

Date of Initial License for Current Owners: 1974

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William E. Castor **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July, 1, 2004 to June 30, 2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Richard A. Walbert
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,473	7,930	6,295	28,698	8
9	SNF/PED					9
10	ICF	9,903	4,934		14,837	10
11	ICF/DD					11
12	SC	3,554	2,026		5,580	12
13	DD 16 OR LESS					13
14	TOTALS	27,930	14,890	6,295	49,115	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.10%

D. How many bed-hold days during this year were paid by the Department?
423 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 06/01/1974

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 160 and days of care provided 6,295

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July, 1, 2004 **Ending:** June 30, 2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	247,399	22,234	9,717	279,350		279,350		279,350			1
2	Food Purchase		210,897		210,897		210,897	1,138	212,035			2
3	Housekeeping	223,825	47,059		270,884		270,884		270,884			3
4	Laundry											4
5	Heat and Other Utilities			171,752	171,752		171,752	7,047	178,799			5
6	Maintenance	72,140	37,452	56,572	166,164		166,164	10,703	176,867			6
7	Other (specify):*											7
8	**TOTAL General Services**	543,364	317,642	238,041	1,099,047		1,099,047	18,888	1,117,935			8
	B. Health Care and Programs											
9	Medical Director			6,400	6,400		6,400		6,400			9
10	Nursing and Medical Records	1,921,114	300,067	57,661	2,278,842		2,278,842	(6,814)	2,272,028			10
10a	Therapy			606,490	606,490		606,490		606,490			10a
11	Activities	31,608			31,608		31,608		31,608			11
12	Social Services	159,013	4,657	12,216	175,886		175,886	(615)	175,271			12
13	CNA Training											13
14	Program Transportation			3,196	3,196		3,196	(2,901)	295			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,111,735	304,724	685,963	3,102,422		3,102,422	(10,330)	3,092,092			16
	C. General Administration											
17	Administrative	95,900	1,239	285,096	382,235		382,235	(215,844)	166,391			17
18	Directors Fees											18
19	Professional Services			10,131	10,131		10,131	12,054	22,185			19
20	Dues, Fees, Subscriptions & Promotions			48,241	48,241		48,241	(31,286)	16,955			20
21	Clerical & General Office Expenses	112,869	6,063	72,165	191,097		191,097	95,994	287,091			21
22	Employee Benefits & Payroll Taxes			622,241	622,241		622,241	34,271	656,512			22
23	Inservice Training & Education											23
24	Travel and Seminar			20,180	20,180		20,180	7,042	27,222			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			136,871	136,871		136,871	1,045	137,916			26
27	Other (specify):*											27
28	**TOTAL General Administration**	208,769	7,302	1,194,925	1,410,996		1,410,996	(96,724)	1,314,272			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,863,868	629,668	2,118,929	5,612,465		5,612,465	(88,166)	5,524,299			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wabash Christian Retirement #0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			158,973	158,973		158,973	21,305	180,278			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,614	53,614		53,614	(18,415)	35,199			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			1,833	1,833		1,833		1,833			36
37	**TOTAL Ownership**			214,420	214,420		214,420	2,890	217,310			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			30,167	30,167		30,167		30,167			39
40	Barber and Beauty Shops		2,437		2,437		2,437		2,437			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):*			47,338	47,338		47,338	(1,134)	46,204			43
44	**TOTAL Special Cost Centers**		2,437	164,010	166,447		166,447	(1,134)	165,313			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,863,868	632,105	2,497,359	5,993,332		5,993,332	(86,410)	5,906,922			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(348)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,520)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(42,444)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,615)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(1,134)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached	(7,549)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,618)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(24,792)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,792)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (86,410)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Wabash Christian Retirement

ID# **0020610**

Report Period Beginning: **July, 1, 2004**

Ending: **June 30, 2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous	$ (1,373)	17	1
2	Vending	1,486	2	2
3	Activity	(615)	12	3
4	Marketing	(31,278)	20	4
5	Exempt Interest Income - Endowment	23,616	32	5
6	Gain on Disposal	10,330	21	6
7	Transportation	(2,901)	14	7
8	Related Pharmacy Profit	(6,814)	10	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,549)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July, 1, 2004 **Ending:** June 30, 2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	1,138	0	0	0	0	0	0	0	0	0	0	1,138	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,520)	12,567	0	0	0	0	0	0	0	0	0	7,047	5
6	Maintenance	0	10,703	0	0	0	0	0	0	0	0	0	10,703	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,382)	23,270	0	0	0	0	0	0	0	0	0	18,888	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,814)	0	0	0	0	0	0	0	0	0	0	(6,814)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(615)	0	0	0	0	0	0	0	0	0	0	(615)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,901)	0	0	0	0	0	0	0	0	0	0	(2,901)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(10,330)	0	0	0	0	0	0	0	0	0	0	(10,330)	16
	C. General Administration													
17	Administrative	(1,373)	(214,471)	0	0	0	0	0	0	0	0	0	(215,844)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,054	0	0	0	0	0	0	0	0	0	12,054	19
20	Fees, Subscriptions & Promotions	(31,286)	0	0	0	0	0	0	0	0	0	0	(31,286)	20
21	Clerical & General Office Expenses	5,715	90,279	0	0	0	0	0	0	0	0	0	95,994	21
22	Employee Benefits & Payroll Taxes	0	34,271	0	0	0	0	0	0	0	0	0	34,271	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,042	0	0	0	0	0	0	0	0	0	7,042	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,045	0	0	0	0	0	0	0	0	0	1,045	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,944)	(69,780)	0	0	0	0	0	0	0	0	0	(96,724)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,656)	(46,510)	0	0	0	0	0	0	0	0	0	(88,166)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Wabash Christian Retirement** **#** **0020610** **Report Period Beginning:** **July, 1, 2004** **Ending:** **June 30, 2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	21,305	0	0	0	0	0	0	0	0	0	21,305	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,828)	413	0	0	0	0	0	0	0	0	0	(18,415)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,828)	21,718	0	0	0	0	0	0	0	0	0	2,890	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,134)	0	0	0	0	0	0	0	0	0	0	(1,134)	43
44	**TOTAL Special Cost Centers**	(1,134)	0	0	0	0	0	0	0	0	0	0	(1,134)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(61,618)	(24,792)	0	0	0	0	0	0	0	0	0	(86,410)	45

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		5	Utilities	$	Christian Homes, Inc	100.00%	$ 12,567	$ 12,567	1
2	V		6	Maintenance				10,703	10,703	2
3	V		17	Administrative	285,096			70,625	(214,471)	3
4	V		19	Professional Services				12,054	12,054	4
5	V		21	Clerical				90,279	90,279	5
6	V		22	Employee Benefits				34,271	34,271	6
7	V		24	Travel & Seminar				7,042	7,042	7
8	V		26	Insurance				1,045	1,045	8
9	V		30	Depreciation				21,305	21,305	9
10	V		32	Interest				413	413	10
11	V									11
12	V									12
13	V									13
14	Total				$ 285,096			$ 260,304	$ * (24,792)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: ne 30, 2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Carmi (TE 95%)		x	Refinance Mortgage	$19,562.50	01/01/90	$ 2,185,000	$ 14,250		0.0750	$ 21,553	1
2	Due to CHI Fund	x			$5,000.00	09/01/97	448,612	491,081		0.0850	30,441	2
3	Financing Fee										1,620	3
4	Inter-company N/P	x						75,000				4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$24,562.50		$ 2,633,612	$ 580,331			$ 53,614	9
	B. Non-Facility Related*											
10	City of Carmi (TE 5%)		x	Refinance Mortgage		01/01/90	115,000	750		0.0750	1,134	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 115,000	$ 750			$ 1,134	14
15	TOTALS (line 9+line14)						$ 2,748,612	$ 581,081			$ 54,748	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Wabash Christian Retirement **#** 0020610 **Report Period Beginning:** July, 1, 2004 **Ending:** June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ n/a	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wabash Christian Retirement COUNTY White

FACILITY IDPH LICENSE NUMBER 0020610

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	This workpaper is not applicable.		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,480 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Duplex Bldgs.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	1974	$ 56,683	1
2	Home Office Allocation			9,152	2
3	TOTALS	217,800		$ 65,835	3

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1974	1958	$ 1,040,410	$ 26,010	40	$ 26,010	$	$ 808,497	4
5	78		1976	1976	724,843	18,121	40	18,121		533,714	5
6											6
7											7
8	Home Office Allocation				66,246	2,135		2,135		33,281	8
	Improvement Type**										
9	Building			1978	13,972	399	35	399		11,015	9
10	Building Improvements Disposed			1979	36,485		18			36,485	10
11	Boiler Room			1981	3,648		15			3,648	11
12	Roof Repairs Disposed			1981	4,080		3			4,080	12
13	Building Improvements			1982	19,950	798	25	798		17,833	13
14	Electrical Supplies			1982	234		20			234	14
15	Rewiring Westside			1982	3,000		20			3,000	15
16	Guttering			1982	9,567		15			9,567	16
17	Wallcovering			1982	1,750		10			1,750	17
18	Heating Control Systems			1982	34,046		20			34,046	18
19	Light Fixtures			1984	1,432		10			1,432	19
20	Floor Tile			1985	6,641		10			6,641	20
21	Vinyl & Labor			1985	397		10			397	21
22	Sewer Work			1985	20,976	699	30	699		14,038	22
23	Nurse Station			1985	7,623	381	20	381		7,525	23
24	Hot Water Heaters			1986	4,900		15			4,900	24
25	Blank										25
26	Roofwork Disposed			1986	7,235		15			7,235	26
27	Boiler System			1986	6,061	303	20	303		5,757	27
28	Floor Tile			1987	977		10			977	28
29	Bathroom Remodel			1987	5,615	281	20	281		5,175	29
30	Wallpaper			1988	870		5			870	30
31	Carpeting			1989	1,086		5			1,086	31
32	Carpeting			1989	800		5			800	32
33	Painting & Papering			1989	856		5			856	33
34	Painting			1989	467		5			467	34
35	Light Fixtures (28)			1989	1,341		10			1,341	35
36	Rooftop A/C Unit (2)			1989	6,280		8			6,280	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof	1989	$ 81,902	$ 4,095	20	$ 4,095	$	$ 63,473	37
38	Tile	1990	1,231		5			1,231	38
39	Faucets	1990	1,716		10			1,716	39
40	Carpeting	1990	3,236		5			3,236	40
41	Carpeting	1990	2,392		5			2,392	41
42	Carpeting	1990	2,298		5			2,298	42
43	Carpeting	1990	2,799		5			2,799	43
44	Rooftop A/C Unit (2)	1991	4,080		8			4,080	44
45	Condensing Unit	1991	1,355		10			1,355	45
46	Steel Doors	1991	1,650	110	15	110		1,522	46
47	New Roof	1991	11,931	795	15	795		10,931	47
48	Light Fixtures	1991	2,189		10			2,189	48
49	Remodel 22 Bathrooms	1992	10,313	516	20	516		6,923	49
50	Steel Doors	1992	1,650	110	15	110		1,476	50
51	Wallpaper	1992	1,695		5			1,695	51
52	Remodel Lobby/Dining Room	1992	12,246	612	20	612		7,344	52
53	Remodel Bathrooms	1992	2,331	117	20	117		1,560	53
54	Carpeting	1992	2,480		5			2,480	54
55	Rooftop A/C Unit	1992	5,338		8			5,338	55
56	Carpeting	1992	3,166		5			3,166	56
57	A/C Units	1992	1,700		5			1,700	57
58	Remodeling	1992	11,704	585	20	585		7,661	58
59	Sound System Disposed	1992	1,563		10			1,563	59
60	Water Heater	1992	1,862	124	15	124		1,581	60
61	Remodeling	1993	6,612		10			6,612	61
62	Wallcovering/base Trim	1993	2,123		5			2,123	62
63	Garage Door	1993	848		10			848	63
64	New Roof Beauty Shop	1993	4,515	301	15	301		3,487	64
65	Rheem Water Heater	1994	2,270		10			2,270	65
66	Door	1994	1,365		10			1,365	66
67	Fire Alarm System	1994	26,850	1,343	20	1,343		14,885	67
68	Egress Locks	1994	2,298	75	10	75		2,298	68
69	Carpeting	1995	545		5			545	69
70	TOTAL (lines 4 thru 69)		$ 2,252,041	$ 57,910		$ 57,910	$	$ 1,737,069	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,252,041	$ 57,910		$ 57,910	$	$ 1,737,069	1
2	Kitchen	1995	85,264	2,750	31	2,750		28,096	2
3	Conc. Trought-Laundry	1995	1,183	91	10	91		1,183	3
4	Remodel Wing	1995	9,535		5			9,535	4
5	Rooftop A/C Unit Eastside	1995	1,800	180	10	180		1,770	5
6	Remodel Wing 8	1996	8,494		5			8,494	6
7	Tile Kitchen	1997	2,304		5			2,304	7
8	Double Doors	1997	736		5			736	8
9	Remodel Wing	1998	5,534		5			5,534	9
10	Activity Bathroom	1998	6,101		5			6,101	10
11	Security Door	1999	984		5			984	11
12	Carpeting Disposed	1999	903		5			903	12
13	Congoleum Flooring	2000	3,540	118	5	118		3,540	13
14	Paint (Wing 4)	2000	3,153	208	5	208		3,153	14
15	Vinyl Floor Covering	2000	1,770	88	5	88		1,770	15
16	Vinyl Floor	2000	720	72	5	72		720	16
17	Border & Wallpaper	2000	736	74	5	74		736	17
18	Kitchen Vinyl	2000	725	97	5	97		725	18
19	Handrails (58)	2000	1,283	86	15	86		437	19
20	3 1/2 ton A/C (Wing 3)	2000	1,900	348	5	348		1,900	20
21	Trane Furnance and A/C System (Wing 2)	2000	8,164	544	15	544		2,765	21
22	Lamenate Flooring (Bath and Kitchen)	2000	2,091	209	10	209		1,062	22
23	Carpet	2000	1,822	305	5	305		1,822	23
24	Carpet (East Wing)	2000	629	125	5	125		629	24
25	Building	2000	236,608	5,915	40	5,915		30,068	25
26	Wing & Bathroom Remodel	2000	23,246	2,325	10	2,325		10,656	26
27	Administrative Wing Remodel	2000	610	15	40	15		78	27
28	Energy Management System	2001	10,000	667	15	667		2,890	28
29	Vinyl Wall Covering	2001	517	103	5	103		421	29
30	Nurse Call System Disposed	2001	783	7	10	7		248	30
31	Heat/AC Control System	2001	4,100	273	15	273		1,206	31
32	Vinyl for the Walls of Wing #4	10/18/2001	1,437	287	5	287		1,076	32
33	Heating/AC Unit & Install Fire Damper	12/3/2001	9,902	660	15	660		2,365	33
34	TOTAL (lines 1 thru 33)		$ 2,688,615	$ 73,457		$ 73,457	$	$ 1,870,976	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,688,615	$ 73,457		$ 73,457	$	$ 1,870,976	1
2	Wallpaper Room 107 Bathroom Ceiling	12/8/2001	537	107	5	107		383	2
3	Remodel Administrators Office	6/30/2002	12,702	847	15	847		2,400	3
4	Vinyl Remnant & Borders/Education Room	5/1/2002	1,314	263	5	263		833	4
5	Installation New Hand Rails/Wings 2 & 5	6/13/2002	2,412	241	10	241		482	5
6	Remodel Administrators Office	7/29/2002	2,084	139	15	139		394	6
7	Replace dry valve on fire alarm/sprinkler	7/24/2002	3,230	323	10	323		969	7
8	Ceiling mount pedant light fixtures	11/21/2002	1,040	104	10	104		277	8
9	Remodel West Lobby	1/17/2003	51,323	5,132	10	5,132		12,830	9
10	Roof flash & seal new HVAC	2/20/2003	3,365	337	10	337		814	10
11	Steel doors for service entry	2/28/2003	1,900	95	20	95		230	11
12	(2) Rooftop AC units	4/25/2003	6,620	662	10	662		1,490	12
13	Move kitchen rooftop AC & ductwork	3/17/2003	6,990	350	20	350		817	13
14	(2)390DEL-LOCKNETICS door for Wing 7	6/30/2003	1,950	130	15	130		271	14
15	Repair ductless AC in dish room	6/30/2003	1,079	216	5	216		450	15
16	Tub Wing 1 Shower room	6/30/2003	641	64	10	64		133	16
17	Nurse call system	6/30/2003	25,795	2,580	10	2,580		5,375	17
18	5 ton Trane 3 phase condensor Wing 1 & 4	6/30/2003	3,450	230	15	230		479	18
19	Repair fire alarm system	6/26/2003	5,692	285	20	285		594	19
20	(2) Del Locks/Power Supply - Wing 7	8/7/2003	2,708	271	10	271		519	20
21	Compressor Wall A/C Unit	8/21/2003	580	116	5	116		222	21
22	Kitchen Fire Suppression System	8/21/2003	2,085	209	10	209		401	22
23	Addition to Nurse Call System	7/15/2003	1,868	187	10	187		374	23
24	Carrier Compressor	7/31/2003	711	237	3	237		474	24
25	Generator & Accessories	8/31/2003	56,551	3,770	15	3,770		6,912	25
26	6 Wall Cabinets	11/4/2003	965	64	15	64		107	26
27	80 Gallon Hot Water Heater	12/8/2003	4,612	461	10	461		730	27
28	Set Commercial Double Doors - East Lobby	2/13/2004	1,236	82	15	82		116	28
29	Carpet/Base - DON Office	6/30/2004	660	132	5	132		143	29
30	Trane 5 Ton Roof Top A/C East Lobby	8/31/2004	6,650	610	10	610		610	30
31	Alzheimer's Wing	10/1/2004	196,102	9,805	15	9,805		9,805	31
32	Trane 2.5 Ton Roof Top A/C Wing 5 Hallway	10/28/2004	3,500	263	10	263		263	32
33	Network Cabling	10/30/2004	37,829	2,837	10	2,837		2,837	33
34	TOTAL (lines 1 thru 33)		$ 3,136,796	$ 104,606		$ 104,606	$	$ 1,923,710	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,136,796	$ 104,606		$ 104,606	$	$ 1,923,710	1
2	Trane 1.5 Ton A/C Computer Server Room	11/15/2004	5,675	379	10	379		379	2
3	Remodeling Wing 3	2/15/2005	7,580	632	5	632		632	3
4	Carpet/Cove Base - Therapy Room	2/7/2005	1,252	104	5	104		104	4
5	Floor Tile/Grout Alzheimer Wing	2/7/2005	530	44	5	44		44	5
6	Roof - West Side of Bldg	4/29/2005	49,880	831	15	831		831	6
7	Handrails/Vinyl - Wings 3 & 9 Hallways	3/2/2005	2,462	164	5	164		164	7
8	Carpet/Base - Room 203	4/30/2005	663	33	5	33		33	8
9	Remodeling Dishwasher Room	5/6/2005	9,365	312	5	312		312	9
10	Replace Sprinkler System Piping	5/25/2005	70,172		10				10
11	Trane Roof Top A/C - Wing 7	5/16/2005	3,050	51	10	51		51	11
12	Land Improvements	6/30/1975	10,000		20			10,000	12
13	Blank								13
14	Blank								14
15	Landscaping	5/31/1981	6,683		14			6,683	15
16	Grading	7/6/1987	1,470	74	20	74		1,332	16
17	Fill & Seal Parking Lot	7/12/1991	2,779		5			2,779	17
18	Sidewalk	5/27/1993	2,395	160	15	160		1,947	18
19	Circular Driveway	10/5/1994	2,628	175	15	175		1,881	19
20	Resurface Parking Lot	7/7/1997	14,035		3			14,035	20
21	Blank								21
22	Waterfall	3/12/1998	908		5			908	22
23	Landscaping - Courtyard	5/29/1998	1,202		5			1,202	23
24	Asphalt - Parking Lot	8/31/1999	7,440	124	5	124		7,440	24
25	Rock for Water Garden	6/17/2000	604	60	10	60		305	25
26	Aquarium - Sere Garden	3/1/2000	1,704	170	10	170		907	26
27	Tree	7/12/2000	500	25	20	25		125	27
28	230' Colonial Style Poly Vinyl Fence	11/16/2001	4,638	309	15	309		1,133	28
29	In-ground Transformer	7/31/2003	18,810	941	20	941		1,882	29
30	Sidewalk repair	8/15/2003	10,060	1,006	10	1,006		1,928	30
31	Concrete Work - Gen Bldg Transformer Pads	8/13/2003	5,312	354	15	354		679	31
32	Trees for Alzheimers Garden	5/22/2004	1,172	59	20	59		64	32
33	Blank								33
34	TOTAL (lines 1 thru 33)		$ 3,379,765	$ 110,613		$ 110,613	$	$ 1,981,490	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,379,765	$ 110,613		$ 110,613	$	$ 1,981,490	1
2	Replace/Extend Sidewalks	6/22/2005	15,057	84	15	84		89	2
3	12x18 Barn	11/22/1999	3,000	300	10	300		1,700	3
4	Bus Port	11/11/2003	3,630	242	15	242		383	4
5	Draperies & Linens	5/23/1990	3,961		5			3,961	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20	Less: Disposals		(51,049)					(50,514)	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,354,364	$ 111,239		$ 111,239	$	$ 1,937,109	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 387,111	$ 43,625	$ 43,625	$	Various	$ 234,000	71
72	Current Year Purchases	98,941	4,709	4,709		Various	4,709	72
73	Fully Depreciated Assets	266,947				Various	266,947	73
74	Home Office Allocation	117,252	16,193	16,193			62,467	74
75	TOTALS	$ 870,251	$ 64,527	$ 64,527	$		$ 568,123	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Ford Bus	1993	$ 39,450	$	$	$	5	$ 39,450	76
77	Patient Transportation	2001 Chrysler Voyager	2004	6,700	1,535	1,535		4	1,535	77
78										78
79	Home Office Allocation			13,767	2,977	2,977			5,237	79
80	TOTALS			$ 59,917	$ 4,512	$ 4,512	$		$ 46,222	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,350,367	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 180,278	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 180,278	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,551,454	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment	$ 493,479	$ 16,247	$ 267,118	86
87	Land	9,227			87
88					88
89					89
90					90
91	TOTALS	$ 502,706	$ 16,247	$ 267,118	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 59,324	92
93			93
94			94
95		$ 59,324	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July, 1, 2004 **Ending:** June 30, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 255,154	$	1
2	Cash-Patient Deposits	28,889		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 38,657)	799,256		3
4	Supply Inventory (priced at FIFO)	24,436		4
5	Short-Term Investments	368,764		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,484		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Int & Other AR	12,806		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,497,789	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,910		13
14	Buildings, at Historical Cost	3,622,883		14
15	Leasehold Improvements, at Historical Cost	136,257		15
16	Equipment, at Historical Cost	821,551		16
17	Accumulated Depreciation (book methods)	(2,717,587)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	626,293		21
22	Other Long-Term Assets (spe CIP	59,324		22
23	Other(specify): Def Bond Cost & Cont Rec	12,993		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,627,624	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,125,413	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 277,918	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,889		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	167,178		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 473,985	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	75,000		39
40	Mortgage Payable			40
41	Bonds Payable	506,081		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Apt. Income	79,399		43
44	Apt. & Cong Life Right & Sec	73,525		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 734,005	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,207,990	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,917,423	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,125,413	$	48

***(See instructions.)**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,083,872	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,083,872	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	550,551	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 550,551	17
	B. Transfers (Itemize):		
18	**Affiliate transfers**	283,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 283,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,917,423	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,752,322	1
2	Discounts and Allowances for all Levels	(521,500)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,230,822	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,077,140	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,077,140	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,823	13
14	Non-Patient Meals	347	14
15	Telephone, Television and Radio	5,520	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,968	19
20	Radiology and X-Ray	6,925	20
21	Other Medical Services	5,117	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 63,700	23
	D. Non-Operating Revenue		
24	Contributions	73,447	24
25	Interest and Other Investment Income***	42,444	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 115,891	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Sale of Equipment	(2,311)	28
28a	Residential/Congregate	58,641	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 56,330	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,543,883	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,099,047	31
32	Health Care	3,102,422	32
33	General Administration	1,410,996	33
	B. Capital Expense		
34	Ownership	214,420	34
	C. Ancillary Expense		
35	Special Cost Centers	79,942	35
36	Provider Participation Fee	86,505	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,993,332	40
41	**Income before Income Taxes (line 30 minus line 40)****	550,551	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 550,551	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,865	1,999	$ 50,280	$ 25.15	1
2	Assistant Director of Nursing	1,940	2,074	41,300	19.91	2
3	Registered Nurses	10,758	11,521	247,172	21.45	3
4	Licensed Practical Nurses	33,936	35,097	543,878	15.50	4
5	CNAs & Orderlies	101,883	105,655	1,001,977	9.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,922	4,079	36,507	8.95	8
9	Activity Director	1,659	1,693	21,700	12.82	9
10	Activity Assistants	1,072	1,095	9,908	9.05	10
11	Social Service Workers	11,504	11,733	159,013	13.55	11
12	Dietician					12
13	Food Service Supervisor	1,906	1,998	26,361	13.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,336	25,084	221,038	8.81	15
16	Dishwashers					16
17	Maintenance Workers	4,010	4,051	72,140	17.81	17
18	Housekeepers	23,585	24,462	223,825	9.15	18
19	Laundry					19
20	Administrator	2,146	2,153	95,900	44.54	20
21	Assistant Administrator					21
22	Other Administrative	1,874	1,880	38,026	20.23	22
23	Office Manager	1,850	1,856	42,219	22.75	23
24	Clerical	3,296	3,307	32,624	9.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	231,542	239,737	$ 2,863,868 *	$ 11.95	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	221	$ 9,717	1.3	35
36	Medical Director	12	5,200	9.3	36
37	Medical Records Consultant	44	3,949	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	190	6,332	10.3	39
40	Physical Therapy Consultant	2,326	138,578	10A.3	40
41	Occupational Therapy Consultant	2,729	156,684	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	643	34,942	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	120	7,146	10A.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	6,285	$ 362,548		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bryant	Administrator	0	$ 95,900
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,900

B. Administrative - Other

Description	Amount
Management Expense	$ 285,096
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 285,096

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 4,667
Mark Stanley	Legal	249
VISA	Consulting	13
Endicott & Finch	Legal	202
Sure Care of KY	Employment	5,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 10,131

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,676
Unemployment Compensation Insurance	6,248
FICA Taxes	206,537
Employee Health Insurance	296,420
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	16,009
Employee Uniforms	502
Employee Physicals	8,547
W C Medical Expense	302
Home Office Allocation	34,271
TOTAL (agree to Schedule V, line 22, col.8)	$ 656,512

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,984
Health Care Worker Background Check (Indicate # of checks performed)	
Licenses	718
Dues	6,543
Subscriptions	1,720
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,955

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,969
Seminar Expense	7,211
Home Office Allocation	7,042
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 27,222

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July, 1, 2004 Ending: June 30, 2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
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Facility Name & ID Number Wabash Christian Retirement **#** 0020610 **Report Period Beginning:** July, 1, 2004 **Ending:** June 30, 20(

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Serv. Network $ 3,313, INHAA $100**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,346** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **86,505**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **348**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Wabash Christian
Allocation on Benefits 6/30/2005 kdb
03/20/06

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	W C Med Expense	Emer Dental Expense	Employee Uniforms	Employee Expense	Employee Physicals		
14,231.00	6,248.00	87,676.25	4,920.00	302.88		501.69	15,875.80	8,546.70	138,302.32	
461.96			6,560.00						7,021.96	
4,986.54			9,840.00				133.52		14,960.06	
18,185.10			26,220.00						44,405.10	
15,853.47			23,760.00						39,613.47	
140,061.96			190,760.00						330,821.96	
12,756.57			34,360.00						47,116.57	
										622,241.44
206,536.60	6,248.00	87,676.25	296,420.00	302.88	0.00	501.69	16,009.32	8,546.70	622,241.44	

Line 3.22.3 525,695.61

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